net providers to continue to offer accessible, affordable, and continuous care to their current patients and to every American who lacks access to preventive and primary care services.

S. CON. RES. 26

At the request of Mr. HARKIN, the names of the Senator from Rhode Island (Mr. WHITEHOUSE), the Senator from Maryland (Mr. CARDIN), the Senator from Indiana (Mr. BAYH) and the Senator from California (Mrs. FEINSTEIN) were added as cosponsors of S. Con. Res. 26, a concurrent resolution apologizing for the enslavement and racial segregation of African Americans.

S. RES. 153

At the request of Mr. KAUFMAN, his name was added as a cosponsor of S. Res. 153, a resolution expressing the sense of the Senate on the restitution of or compensation for property seized during the Nazi and Communist eras.

AMENDMENT NO. 1303

At the request of Ms. LANDRIEU, the names of the Senator from Iowa (Mr. HARKIN) and the Senator from Maryland (Mr. CARDIN) were added as cosponsors of amendment No. 1303 intended to be proposed to S. 1023, a bill to establish a non-profit corporation to communicate United States entry policies and otherwise promote leisure, business, and scholarly travel to the United States.

AMENDMENT NO. 1311

At the request of Ms. COLLINS, her name was added as a cosponsor of amendment No. 1311 intended to be proposed to S. 1023, a bill to establish a non-profit corporation to communicate United States entry policies and otherwise promote leisure, business, and scholarly travel to the United States.

AMENDMENT NO. 1312

At the request of Mr. SANDERS, the names of the Senator from Michigan (Ms. STABENOW) and the Senator from New York (Mr. SCHUMER) were added as cosponsors of amendment No. 1312 intended to be proposed to S. 1023, a bill to establish a non-profit corporation to communicate United States entry policies and otherwise promote leisure, business, and scholarly travel to the United States.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. ROCKEFELLER (for himself and Mr. BROWN):

S. 1278. A bill to establish the Consumers Choice Health Plan, a public health insurance plan that provides an affordable and accountable health insurance option for consumers; to the Committee on Finance.

Mr. ROCKEFELLER. Mr. President, there is a stark choice looming before Congress. It is the choice between enacting a comprehensive reform bill that truly improves our health care system for the American people or enacting a mediocre reform bill that largely maintains the status quo—which is an ineffective and costly health care system run by the insurance industry. I know that most of my colleagues want the former—a 21st Century health care system that provides meaningful and affordable coverage for all, improves health outcomes, and brings accountability and responsibility back into health care.

I am absolutely convinced that the inclusion of a strong public health insurance plan option is the only way to guarantee that all consumers have affordable, adequate, and accountable options available in the insurance marketplace. It is for this reason that I rise today with my good friend, Senator SHERROD BROWN of Ohio, to introduce the Consumers Health Care Act of 2009—legislation to provide a strong public plan option in the National Health Insurance Exchange.

One of the most contentious, yet critical, pieces of the national health care reform effort is whether or not Americans should have the option to buy their health insurance from a publicly run organization. In other words, in addition to choosing among numerous health plans run by private insurers, should consumers also have the option of choosing an affordable, stable, and transparent public plan when they are deciding what is best for them and their families? I believe consumers should have the option of choosing a public plan.

Opponents of giving Americans a public option regularly use alarmist rhetoric such as ''big government'' and ''socialized medicine.'' And, somehow, protecting the rights of private health insurers to make profits has become more important to some than offering Americans the choice of a plan that seeks to insure everyone, no matter how sick, that is less expensive, and that is responsible to the American people—not to private profit-seeking stockholders.

I'm not sure when the word ''public'' became such a bad word in the eyes of some of my colleagues. Public means acting in the interest of the general public—which is exactly what we should aspire to in comprehensive health reform.

The private health insurance market has significantly contributed to the broken nature of our health care system, with a long history of cutting coverage off or charging too much for too little. A public plan option—repeat, option—is an effective way to bring competition to the insurance market, hold down costs, and encourage innovation and quality improvements. To deny this option is not only shortsighted, but downright harmful.

Everyone knows the sobering statistics that have highlighted the need for comprehensive health reform. More than 45 million Americans are uninsured and another 25 million are underinsured. Since 1909, the average health insurance premium for a family has increased by 119 percent, from $5,791 in 1999 to $12,680 in 2008. Yet, Americans have seen their benefits decrease and have faced substantially larger out-of-pocket expenses. An estimated 62 percent of all personal bankruptcies involve medical expenses and 78 percent of the individuals who cited medical expenses in their bankruptcy claims had health insurance. Health care costs already consume 17 percent of the United State's gross domestic product, which everyone can agree is unsustainable.

However, representing the great state of West Virginia has shown me that the need for health reform is far more essential and personal than frightening statistics could ever show. I have listened at roundtable discussions where West Virginians described how the current health care system has failed them. One woman was really struggling to care for both herself and her son. She was uninsured because her son, who had a serious brain disorder, needed 24 hour a day, seven day a week, assistance. Another family wrote to me because their son, who was born with serious congenital heart defects, had reached the $1 million limit on his mother's insurance policy within the first nine months of his life. They were unsure of how to obtain lifesaving treatment for their son, now that the insurance company would no longer pay for his care. I have heard from countless other West Virginians who have been unable to find affordable health care, or have figured out too late that the health insurance they had was inadequate for what they needed.

As Congress works to achieve the transformative reform necessary to create a sustainable health care system, a vital component of this reform is the inclusion of a strong public plan option like the Consumer Choice Health Plan included in the Consumers Health Care Act. A public plan will help establish a new insurance framework, one that compels insurers to provide Americans with the best value for their health care at the best price, rather than the current insurance framework, which is focused on avoiding risk and increasing profits. The Consumer Choice Health Plan will be available for all individuals and small businesses, regardless of health status, and will not be concerned with paying a CEO salary or broker commissions.

The Consumers Health Care Act will increase transparency and accountability throughout the health insurance market, as well as give individuals guaranteed access to health care coverage should they be denied or priced out of affordable private insurance coverage. Currently, insurers are allowed to operate in a black box, with little oversight of their coverage and payment decisions. Individuals with pre-existing conditions are routinely denied access to affordable care. For years, United Health was able to underpay providers and overcharge patients for out-of-network services. The Consumers Health Care Act will address this and other issues by bringing greater transparency to the private health insurance market.

Consumer Choice Health Plans will serve as a vital safety-net of coverage for individuals and families that have been unable to obtain affordable and comprehensive health care coverage through the private market. A private insurance company's desire to earn greater profits will always trump over the need to make health care coverage affordable and accessible to all Americans, and greater insurance regulation is not enough. The Consumers Health Care Act is necessary in order to achieve the sustainable change that the health care system in this country needs.

I trust the good sense of the American public to choose the health coverage they want, and they deserve the choice of a public plan with lower costs and the guarantee of always being there when they need it. The American people trust us to get this right and deliver the best coverage options that will keep their families healthy and safe. The days of packaging half-baked legislation into a bill and calling it transformative reform when it is not have to end now, or the shame is on all of us:

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 1278

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Consumers Health Care Act of 2009''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Americans need health care coverage that is always affordable.

(2) Americans need health care coverage that is always adequate.

(3) Americans need health care coverage that is always accountable.

(4) A public health insurance plan option that can compete with private insurance plans is the only way to guarantee that all consumers have affordable, adequate, and accountable options available in the insurance marketplace.

SEC. 3. OFFICE OF HEALTH PLAN MANAGEMENT.

(a) ESTABLISHMENT.—Not later than July 1, 2010, there shall be established within the Department of Health and Human Services an Office of Health Plan Management (referred to in this Act as the ''Office''). The Office shall be headed by a Director (referred to in this Act as the ''Director'') who shall be appointed by the President, by and with the advice and consent of the Senate.

(b) COMPENSATION.—The Director shall be paid at the annual rate of pay for a position at level II of the Executive Schedule under section 5313 of title 5, United States Code.

(c) LIMITATION.—Neither the Director nor the Office shall participate in the administration of the National Health Insurance Exchange (as defined in section 7) or the promulgation or administration of any regulation regarding the health insurance industry.

(d) PERSONNEL AND OPERATIONS AUTHORITY.—The Director shall have the same general authorities with respect to personnel and operations of the Office as the heads of other agencies and departments of the Federal Government have with respect to such agencies and departments.

SEC. 4. CONSUMER CHOICE HEALTH PLAN.

(a) IN GENERAL.—The Office shall establish and administer the Consumer Choice Health Plan (referred to in this Act as the ''Plan'') to provide for health insurance coverage that is made available to all eligible individuals (as described in subsection (d)(1)) in the United States and its territories.

(b) REGULATORY COMPLIANCE.—The Plan shall comply with—

(1) all regulations and requirements that are applicable with respect to other health insurance plans that are offered through the National Health Insurance Exchange; and

(2) any additional regulations and requirements, as determined by the Director.

(c) BENEFITS.—

(1) IN GENERAL.—The Plan shall offer health insurance coverage at different benefit levels, provided that such benefits are commensurate with the required benefit levels to be provided by a health insurance plan under the National Health Insurance Exchange.

(2) MINIMUM BENEFITS FOR CHILDREN.—

(A) IN GENERAL.—The minimum benefit level available under the Plan for children shall include at least the services described in the most recently published version of the ''Maternal and Child Health Plan Benefit Model'' developed by the National Business Group on Health.

(B) AMENDMENT OF BENEFIT LEVEL.—The Secretary of Health and Human Services, acting through the Director of the Agency for Healthcare Research and Quality, may amend the benefits described in subparagraph (A) based on the most recent peer-reviewed and evidence-based data.

(d) ELIGIBILITY AND ENROLLMENT.—

(1) ELIGIBILITY.—An individual who is eligible to purchase coverage from a health insurance plan through the National Health Insurance Exchange shall be eligible to enroll in the Plan.

(2) ENROLLMENT PROCESS.—An individual may enroll in the Plan only in such manner and form as may be prescribed by applicable regulations, and only during an enrollment period as prescribed by the Director.

(3) EMPLOYER ENROLLMENT.—An employer shall be eligible to purchase health insurance coverage for their employees and the employees' dependents to the extent provided for all health benefits plans under the National Health Insurance Exchange.

(4) SATISFACTION OF INDIVIDUAL MANDATE REQUIREMENT.—An individual's enrollment with the Plan shall be treated as satisfying any requirement under Federal law for such individual to demonstrate enrollment in health insurance or benefits coverage.

(e) PROVIDERS.—

(1) NETWORK REQUIREMENT.—

(A) MEDICARE.—A participating provider who is voluntarily providing health care services under the Medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) shall be required to provide services to any individual enrolled in the Plan.

(B) MEDICAID AND CHIP.—A provider of health care services under the Medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or the CHIP program established under title XXI of such Act (42 U.S.C. 1397aa et seq.), shall be required to provide services to any individual enrolled in the Plan.

(2) EXCEPTION.—Paragraph (1) shall not be construed as requiring a provider to accept new patients due to bona fide capacity limitations of the provider.

(3) OPT-OUT PROVISION.—

(A) MEDICARE.—A participating provider as described under paragraph (1)(A) shall be required to provide services to any individual enrolled in the Plan for the 3-year period following the establishment of the Plan. Upon the expiration of the 3-year period, a participating provider in the Plan may elect to become a non-participating provider without affecting their status as a participating provider under the Medicare program.

(B) MEDICAID AND CHIP.—A provider as described under paragraph (1)(B) shall be required to provide services to any individual enrolled in the Plan for the 3-year period following the establishment of the Plan. Upon the expiration of the 3-year period, a provider in the Plan may elect to cease provision of services under the Plan without affecting their status as a provider under the Medicaid program or the CHIP program.

(4) PAYMENT RATES.—

(A) INITIAL PAYMENT RATES.—

(i) IN GENERAL.—During the 2-year period following the establishment of the Plan, providers shall be reimbursed at such payment rates as are applicable under the Medicare program.

(ii) ADJUSTMENT.—The Director may reimburse providers at rates lower or higher than applicable under the Medicare program if the Director determines that the adjusted rates are appropriate and ensure that enrollees in the Plan are provided with adequate access to health care services.

(B) SUBSEQUENT PAYMENT RATES.—Subject to subparagraph (C), upon the expiration of the 2-year period following the establishment of the Plan, the Director shall develop payment rates for reimbursement of providers in order to maintain an adequate provider network necessary to assure that enrollees in the Plan have adequate access to health care. In determining such payment rates, the Director shall consider—

(i) competitive provider payment rates in both the public and private sectors;

(ii) best practices among providers;

(iii) integrated models of care delivery (including medical home and chronic care coordination models);

(iv) geographic variation in health care costs;

(v) evidence-based practices;

(vi) quality improvement;

(vii) use of health information technology; and

(viii) any additional measures, as determined by the Director.

(C) PAYMENT RATE CONSULTATION.—The Director shall determine payment rates under subparagraph (B) in consultation with providers participating under the Plan, the Director of the Office of Personnel Management, the Medicare Payment Advisory Commission, and the Medicaid and CHIP Payment and Access Commission.

(5) ADOPTION OF MEDICARE REFORMS.—The Plan may adopt Medicare system delivery reforms that provide patients with a coordinated system of care and make changes to the provider payment structure.

(f) SUBSIDIES.—The Plan shall be eligible to accept subsidies, including subsidies for the enrollment of individuals under the Plan, in the same manner and to the same extent as other health insurance plans offered through the National Health Insurance Exchange.

(g) FINANCING.—

(1) TRANSITIONAL FUNDING.—

(A) IN GENERAL.—In order to provide for adequate funding of the Plan in advance of receipt of payments as described in paragraph (2), beginning July 1, 2010, there are transferred to the Plan from the general fund of the Treasury such amounts as may be necessary for operation of the Plan until the end of the 3-year period following the establishment of the Plan.

(B) RETURN OF FUNDS.—Upon the expiration of the 3-year period following the establishment of the Plan, the Director shall enter into a repayment schedule with the Secretary of the Treasury to provide for repayment of funds provided under subparagraph (A). Any expenditures made by the Plan pursuant to a repayment schedule established under this subparagraph shall not constitute administrative expenses as described in paragraph (2)(B).

(2) SELF-FINANCING.—

(A) IN GENERAL.—The Plan shall be financially self-sustaining insofar as funds used for operation of the Plan (including benefits, administration, and marketing) shall be derived from—

(i) insurance premium payments and subsidies for individuals enrolled in the Plan; and

(ii) payments made to the Plan by employers that do not offer health insurance coverage to their employees.

(B) LIMITATION ON ADMINISTRATIVE EXPENSES.—Not more than 5 percent of the amounts provided under subparagraph (A) may be used for the annual administrative costs of the Plan.

(3) CONTINGENCY RESERVE.—

(A) IN GENERAL.—The Director shall establish and fund a contingency reserve for the Plan in a form similar to the contingency reserve provided for health benefits plans under the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code.

(B) REVENUE.—Any revenue generated through the contingency reserve established in subparagraph (A) shall be transferred to the Plan for the purpose of reducing enrollee premiums, reducing enrollee cost-sharing, increasing enrollee benefits, or any combination thereof.

(4) GAO FINANCIAL AUDIT AND REPORT.—Beginning not later than October 1, 2011, the Comptroller General shall conduct an annual audit of the financial statements and records of the Plan, in accordance with generally accepted government auditing standards, and submit an annual report on such audit to the Congress.

(5) SUPERMAJORITY REQUIREMENT FOR SUPPLEMENTAL FUNDING.—Upon certification by the Comptroller General that the financial audit described in paragraph (4) indicates that the Plan is insolvent, supplemental funding may be appropriated for the Plan if such measure receives not less than a three-fifths vote of approval of the total number of Members of the House of Representatives and the Senate.

(h) TRANSPARENCY.—

(1) IN GENERAL.—Beginning with the first year of operation of the Plan through the National Health Insurance Exchange, the Director shall provide standards and undertake activities for promoting transparency in costs, benefits, and other factors for health insurance coverage provided under the Plan.

(2) STANDARD DEFINITIONS OF INSURANCE AND MEDICAL TERMS.—

(A) IN GENERAL.—The Director shall provide for the development of standards for the definitions of terms used in health insurance coverage under the Plan, including insurance-related terms (including the insurance-related terms described in subparagraph (B)) and medical terms (including the medical terms described in subparagraph (C)).

(B) INSURANCE-RELATED TERMS.—The insurance-related terms described in this subparagraph are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Director determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.

(C) MEDICAL TERMS.—The medical terms described in this subparagraph are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Director determines are important to define so that consumers may compare the medical benefits offered by health insurance plans and understand the extent of those medical benefits (or exceptions to those benefits).

(3) DISCLOSURE.—

(A) IN GENERAL.—In carrying out this subsection, the Director shall disclose to Plan enrollees, potential enrollees, in-network health care providers, and others (through a publically available Internet website and other appropriate means) relevant information regarding each policy of health insurance coverage marketed or in force (in such standardized manner as determined by the Director), including—

(i) full policy contract language; and

(ii) a summary of the information described in paragraph (4).

(B) PERSONALIZED STATEMENT.—The Director shall disclose to enrollees (in such standardized manner as determined by the Director) an annual personalized statement that summarizes use of health care services and payment of claims with respect to an enrollee (and covered dependents) under health insurance coverage provided through the Plan in the preceding year.

(4) REQUIRED INFORMATION.—The information described in this paragraph includes, but is not limited to, the following:

(A) Data on the price of each new policy of health insurance coverage and renewal rating practices.

(B) Claims payment policies and practices, including how many and how quickly claims were paid.

(C) Provider fee schedules and usual, customary, and reasonable fees (for both in-network and out-of-network providers).

(D) Provider participation and provider directories.

(E) Loss ratios, including detailed information about amount and type of non-claims expenses.

(F) Covered benefits, cost-sharing, and amount of payment provided toward each type of service identified as a covered benefit, including preventive care services recommended by the United States Preventive Services Task Force.

(G) Civil or criminal actions successfully concluded against the Plan by any governmental entity.

(H) Benefit exclusions and limits.

(5) DEVELOPMENT OF PATIENT CLAIMS SCENARIOS.—

(A) IN GENERAL.—In order to improve the ability of individuals and employers to compare the coverage and relative value provided under the Plan, the Director shall develop and make publically available a series of patient claims scenarios under which benefits (including out-of-pocket costs) under the Plan are simulated for certain common or expensive conditions or courses of treatment (including maternity care, breast cancer, heart disease, diabetes management, and well-child visits).

(B) CONSULTATION.—The Director shall develop the patient claims scenarios described in subparagraph (A)—

(i) in consultation with the Secretary of Health and Human Services, the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, health professional societies, patient advocates, and other entities as deemed necessary by the Director; and

(ii) based upon recognized clinical practice guidelines.

(6) MANNER OF DISCLOSURE.—The Director shall disclose the information under this subsection—

(A) with all marketing materials;

(B) on the website for the Plan; and

(C) at other times upon request.

SEC. 5. ESTABLISHMENT OF AMERICA'S HEALTH INSURANCE TRUST.

(a) ESTABLISHMENT.—As of the date of enactment of this Act, there is authorized to be established a non-profit corporation that shall be known as the ''America's Health Insurance Trust'' (referred to in this Act as the ''Trust''), which is neither an agency nor establishment of the United States Government.

(b) LOCATION; SERVICE OF PROCESS.—The Trust shall maintain its principal office within the District of Columbia and have a designated agent in the District of Columbia to receive service of process for the Trust. Notice to or service on the agent shall be deemed as notice to or service on the corporation.

(c) APPLICATION OF PROVISIONS.—The Trust shall be subject to the provisions of this section and, to the extent consistent with this section, to the District of Columbia Nonprofit Corporation Act.

(d) TAX EXEMPT STATUS.—The Trust shall be treated as a nonprofit organization described under section 170(c)(2)(B) and section 501(c)(3) of the Internal Revenue Code of 1986 that is exempt from taxation under section 501(a) of the Internal Revenue Code of 1986.

(e) BOARD OF DIRECTORS.—

(1) IN GENERAL.—The Board of Directors of the Trust (referred to in this Act as the ''Board'') shall consist of 19 voting members appointed by the Comptroller General.

(2) TERMS.—

(A) IN GENERAL.—Subject to subparagraph (C), each member of the Board shall serve for a term of 6 years.

(B) LIMITATION.—No individual shall be appointed to the Board for more than 2 consecutive terms.

(C) INITIAL MEMBERS.—The initial members of the Board shall be appointed by the Comptroller General not later than October 1, 2010, and shall serve terms as follows:

(i) 8 members shall be appointed for a term of 5 years.

(ii) 8 members shall be appointed for a term of 3 years.

(iii) 3 members shall be appointed for a term of 1 year.

(D) EXPIRATION OF TERM.—Any member of the Board whose term has expired may serve until such member's successor has taken office, or until the end of the calendar year in which such member's term has expired, whichever is earlier.

(E) VACANCIES.—

(i) IN GENERAL.—Any member appointed to fill a vacancy prior to the expiration of the term for which such member's predecessor was appointed shall be appointed for the remainder of such term.

(ii) VACANCIES NOT TO AFFECT POWER OF BOARD.—A vacancy on the Board shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

(3) CHAIRPERSON AND VICE-CHAIRPERSON.—

(A) IN GENERAL.—The Comptroller General shall designate a Chairperson and Vice-Chairperson of the Board from among the members of the Board.

(B) TERM.—The members designated as Chairperson and Vice-Chairperson shall serve for a period of 3 years.

(4) CONFLICTS OF INTEREST.—An individual may not serve on the Board if such individual (or an immediate family member of such individual) is employed by or has a financial interest in—

(A) an organization that provides a health insurance plan;

(B) a pharmaceutical manufacturer; or

(C) any subsidiary entities of an organization described in subparagraphs (A) or (B).

(5) COMPOSITION OF THE BOARD.—

(A) POLITICAL PARTIES.—Not more than 10 members of the Board may be affiliated with the same political party.

(B) DIVERSITY.—In appointing members under this paragraph, the Comptroller General shall ensure that such members provide appropriately diverse representation with respect to race, ethnicity, age, gender, and geography.

(C) CONSUMER REPRESENTATION.—10 members of the Board shall be independent and non-conflicted individuals representing the interests of health care consumers. Each member selected under this subparagraph shall represent 1 of the 10 Department of Health and Human Services regions in the United States.

(D) REMAINING REPRESENTATION.—

(i) IN GENERAL.—9 members of the Board shall be selected based on relevant experience, including expertise in—

(I) community affairs;

(II) Federal, State, and local government;

(III) health professions and administration;

(IV) business, finance, and accounting;

(V) legal affairs;

(VI) insurance;

(VII) trade unions;

(VIII) social services; and

(IX) any additional areas as determined by the Comptroller General.

(ii) INCOME FROM HEALTH CARE INDUSTRY.—Not more than 4 of the members selected under this subparagraph shall earn more than 10 percent of their income from the health care industry.

(6) MEETINGS AND HEARINGS.—The Board shall meet and hold hearings at the call of the Chairperson or a majority of its members. Meetings of the Board on matters not related to personnel shall be open to the public and advertised through public notice at least 7 days prior to the meeting.

(7) QUORUM.—A majority of the members of the Board shall constitute a quorum for purposes of conducting the duties of the Trust, but a lesser number of members may meet and hold hearings.

(8) EXECUTIVE DIRECTOR AND STAFF; PERFORMANCE OF DUTIES.—The Board may—

(A) employ and fix the compensation of an Executive Director and such other personnel as may be necessary to carry out the duties of the Trust;

(B) seek such assistance and support as may be required in the performance of the duties of the Trust from appropriate departments and agencies of the Federal Government;

(C) enter into contracts or other arrangements and make such payments as may be necessary for performance of the duties of the Trust;

(D) provide travel, subsistence, and per diem compensation for individuals performing the duties of the Trust, including members of the Advisory Council (as described in subsection (f)); and

(E) prescribe such rules, regulations, and bylaws as the Board determines necessary with respect to the internal organization and operation of the Trust.

(9) LOBBYING COOLING-OFF PERIOD FOR MEMBERS OF THE BOARD.—Section 207(c) of title 18, United States Code, is amended by inserting at the end the following:

''(3) MEMBERS OF THE BOARD OF DIRECTORS OF THE AMERICA'S HEALTH INSURANCE TRUST.—Paragraph (1) shall apply to a member of the Board of Directors of the America's Health Insurance Trust who was appointed to the Board as of the day before the date of enactment of the Consumers Health Care Act of 2009.''.

(f) ADVISORY COUNCIL.—

(1) ESTABLISHMENT.—The Board shall establish an advisory council that shall be comprised of the insurance commissioners of each State (including the District of Columbia) to advise the Board on the development and impact of measures to improve the transparency and accountability of health insurance plans provided through the National Health Insurance Exchange.

(2) MEETINGS.—The advisory council shall meet not less than twice a year and at the request of the Board.

(g) FINANCIAL OVERSIGHT.—

(1) CONTRACT FOR AUDITS.—The Trust shall provide for financial audits of the Trust on an annual basis by a private entity with expertise in conducting financial audits.

(2) REVIEW AND REPORT ON AUDITS.—The Comptroller General shall—

(A) review and evaluate the results of the audits conducted pursuant to paragraph (1); and

(B) submit a report to Congress containing the results and review of such audits, including an analysis of the adequacy and use of the funding for the Trust and its activities.

(h) RULES ON GIFTS AND OUTSIDE CONTRIBUTIONS.—

(1) GIFTS.—The Trust (including the Board and any staff acting on behalf of the Trust) shall not accept gifts, bequeaths, or donations of services or property.

(2) PROHIBITION ON OUTSIDE FUNDING OR CONTRIBUTIONS.—The Trust shall not—

(A) establish a corporation other than as provided under this section; or

(B) accept any funds or contributions other than as provided under this section.

(i) AMERICA'S HEALTH INSURANCE TRUST FUND.—

(1) IN GENERAL.—There is established in the Treasury a trust fund to be known as the ''America's Health Insurance Trust Fund'' (referred to in this section as the ''Trust Fund''), consisting of such amounts as may be credited to the Trust Fund as provided under this subsection.

(2) TRANSFER.—The Secretary of the Treasury shall transfer to the Trust Fund out of the general fund of the Treasury amounts determined by the Secretary to be equivalent to the amounts received into such general fund that are attributable to the fees collected under sections 4375 and 4376 of the Internal Revenue Code of 1986 (relating to fees on health insurance policies and self-insured health plans).

(3) FINANCING FOR FUND FROM FEES ON INSURED AND SELF-INSURED HEALTH PLANS.—

(A) GENERAL RULE.—Chapter 34 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

''Subchapter B—Insured and Self-Insured Health Plans

''Sec. 4375. Health insurance.

''Sec. 4376. Self-insured health plans.

''Sec. 4377. Definitions and special rules.

''SEC. 4375. HEALTH INSURANCE.

''(a) IMPOSITION OF FEE.—In the case of any specified health insurance policy issued after October 1, 2009, there is hereby imposed a fee equal to—

''(1) for policies issued during fiscal years 2010 through 2013, 50 cents multiplied by the average number of lives covered under the policy; and

''(2) for policies issued after September 30, 2013, $1 multiplied by the average number of lives covered under the policy.

''(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

''(c) SPECIFIED HEALTH INSURANCE POLICY.—For purposes of this section:

''(1) IN GENERAL.—Except as otherwise provided in this section, the term 'specified health insurance policy' means any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States.

''(2) EXEMPTION FOR CERTAIN POLICIES.—The term 'specified health insurance policy' does not include any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

''(3) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

''(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B)—

''(i) such arrangement shall be treated as a specified health insurance policy, and

''(ii) the person referred to in such subparagraph shall be treated as the issuer.

''(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

''(d) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any policy issued in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such policy shall be equal to the sum of such dollar amount for policies issued in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

''(1) such dollar amount for policies issued in the previous fiscal year, multiplied by

''(2) the percentage increase in the projected per capita amount of National Health Expenditures from the calendar year in which the previous fiscal year ends to the calendar year in which the fiscal year involved ends, as most recently published by the Secretary of Health and Human Services before the beginning of the fiscal year.

''(e) TERMINATION.—This section shall not apply to policy years ending after September 30, 2019.

''SEC. 4376. SELF-INSURED HEALTH PLANS.

''(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan issued after October 1, 2009, there is hereby imposed a fee equal to—

''(1) for plans issued during fiscal years 2010 through 2013, 50 cents multiplied by the average number of lives covered under the plan; and

''(2) for plans issued after September 30, 2013, $1 multiplied by the average number of lives covered under the plans.

''(b) LIABILITY FOR FEE.—

''(1) IN GENERAL.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

''(2) PLAN SPONSOR.—For purposes of paragraph (1) the term 'plan sponsor' means—

''(A) the employer in the case of a plan established or maintained by a single employer,

''(B) the employee organization in the case of a plan established or maintained by an employee organization,

''(C) in the case of—

''(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

''(ii) a multiple employer welfare arrangement, or

''(iii) a voluntary employees' beneficiary association described in section 501(c)(9),

the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

''(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

''(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term 'applicable self-insured health plan' means any plan for providing accident or health coverage if—

''(1) any portion of such coverage is provided other than through an insurance policy, and

''(2) such plan is established or maintained—

''(A) by one or more employers for the benefit of their employees or former employees,

''(B) by one or more employee organizations for the benefit of their members or former members,

''(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

''(D) by a voluntary employees' beneficiary association described in section 501(c)(9),

''(E) by any organization described in section 501(c)(6), or

''(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

''(d) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any plan issued in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such plan shall be equal to the sum of such dollar amount for plans issued in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

''(1) such dollar amount for plans issued in the previous fiscal year, multiplied by

''(2) the percentage increase in the projected per capita amount of National Health Expenditures from the calendar year in which the previous fiscal year ends to the calendar year in which the fiscal year involved ends, as most recently published by the Secretary of Health and Human Services before the beginning of the fiscal year.

''(e) TERMINATION.—This section shall not apply to plans issued after September 30, 2019.

''SEC. 4377. DEFINITIONS AND SPECIAL RULES.

''(a) DEFINITIONS.—For purposes of this subchapter—

''(1) ACCIDENT AND HEALTH COVERAGE.—The term 'accident and health coverage' means any coverage which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

''(2) INSURANCE POLICY.—The term 'insurance policy' means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

''(3) UNITED STATES.—The term 'United States' includes any possession of the United States.

''(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

''(1) IN GENERAL.—For purposes of this subchapter—

''(A) the term 'person' includes any governmental entity, and

''(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subchapter except as provided in paragraph (2).

''(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program, no fee shall be imposed under section 4375 or section 4376 on any covered policy or plan under such program.

''(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term 'exempt governmental program' means—

''(A) any insurance program established under title XVIII of the Social Security Act,

''(B) the medical assistance program established by title XIX or XXI of the Social Security Act,

''(C) the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code,

''(D) the Consumer Choice Health Plan established under the Consumers Health Care Act of 2009,

''(E) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being—

''(i) members of the Armed Forces of the United States, or

''(ii) veterans, and

''(F) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

''(c) TREATMENT AS TAX.—For purposes of subtitle F, the fees imposed by this subchapter shall be treated as if they were taxes.

''(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.''.

(B) CLERICAL AMENDMENTS.—

(i) Chapter 34 of such Code is amended by striking the chapter heading and inserting the following:

''CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

''SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

''SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

''Subchapter A—Policies Issued By Foreign Insurers''.

(ii) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 34 and inserting the following new item:

''CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES''.

SEC. 6. DUTIES OF AMERICA'S HEALTH INSURANCE TRUST.

(a) INSURANCE PLAN RANKINGS AND WEBSITE.—

(1) WEB-BASED MATERIALS.—The Trust shall establish and maintain a website that provides informational materials regarding the health insurance plans provided through the National Health Insurance Exchange, including appropriate links for all available State insurance commissioner websites.

(2) PLAN RANKINGS.—The Trust shall develop and publish annual rankings of the health insurance plans provided through the National Health Insurance Exchange, based on the assignment of a letter grade between ''grade A'' (highest) and ''grade F'' (lowest). The Trust shall provide for a comparative evaluation of each plan based upon—

(A) administrative expenditures;

(B) affordability of coverage;

(C) adequacy of coverage;

(D) timeliness and adequacy of consumer claims processing;

(E) available consumer complaint systems;

(F) grievance and appeals processes;

(G) transparency;

(H) consumer satisfaction; and

(I) any additional measures as determined by the Board.

(3) INFORMATION AVAILABLE ON WEBSITE BY ZIP CODE.—The annual rankings of the health insurance plans (as described in paragraph (2)) shall be available on the website for the Trust (as described in paragraph (1)), and the website for the National Health Insurance Exchange, in a manner that is searchable and sortable by zip code.

(4) CONSUMER FEEDBACK.—

(A) CONSUMER COMPLAINTS.—The Trust shall develop written and web-based methods for individuals to provide recommendations and complaints regarding the health insurance plans provided through the National Health Insurance Exchange.

(B) CONSUMER SURVEYS.—The Trust shall obtain meaningful consumer input, including consumer surveys, that measure the extent to which an individual receives the services and supports described in the individual's health insurance plan and the individual's satisfaction with such services and supports.

(b) DATA SHARING.—

(1) IN GENERAL.—An organization that provides a health insurance plan through the National Health Insurance Exchange shall provide the Trust with all information and data that is necessary for improving transparency, monitoring, and oversight of such plans.

(2) ANNUAL DISCLOSURE.—Beginning with the first full year of operation of the National Health Insurance Exchange, an organization that provides a health insurance plan through the National Health Insurance Exchange shall annually provide the Trust with appropriate information regarding the following:

(A) Name of the plan.

(B) Levels of available plan benefits.

(C) Description of plan benefits.

(D) Number of enrollees under the plan.

(E) Demographic profile of enrollees under the plan.

(F) Number of claims paid to enrollees.

(G) Number of enrollees that terminated their coverage under the plan.

(H) Total operating cost for the plan (including administrative costs).

(I) Patterns of utilization of the plan's services.

(J) Availability, accessibility, and acceptability of the plan's services.

(K) Such information as the Trust may require demonstrating that the organization has a fiscally sound operation.

(L) Any additional information as determined by the Trust.

(3) FORM AND MANNER OF INFORMATION.—Information to be provided to the Trust under paragraphs (1) and (2) shall be provided—

(A) in such form and manner as specified by the Trust; and

(B) within 30 days of the date of receipt of the request for such information, or within such extended period as the Trust deems appropriate.

(4) INFORMATION FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—

(A) IN GENERAL.—Any information regarding the health insurance plans that are offered through the National Health Insurance Exchange that has been provided to the Secretary of Health and Human Services shall also be made available (as deemed appropriate by the Secretary) to the Trust for the purpose of improving transparency, monitoring, and oversight of such plans. Such information may include, but is not limited to, the following:

(i) Underwriting guidelines to ensure compliance with applicable Federal health insurance requirements.

(ii) Rating practices to ensure compliance with applicable Federal health insurance requirements.

(iii) Enrollment and disenrollment data, including information the Secretary may need to detect patterns of discrimination against individuals based on health status or other characteristics, to ensure compliance with applicable Federal health insurance requirements (including non-discrimination in group coverage, guaranteed issue, and guaranteed renewability requirements applicable in all markets).

(iv) Post-claims underwriting and rescission practices to ensure compliance with applicable Federal health insurance requirements relating to guaranteed renewability.

(v) Marketing materials and agent guidelines to ensure compliance with applicable Federal health insurance requirements.

(vi) Data on the imposition of pre-existing condition exclusion periods and claims subjected to such exclusion periods.

(vii) Information on issuance of certificates of creditable coverage.

(viii) Information on cost-sharing and payments with respect to any out-of-network coverage.

(ix) The application to issuers of penalties for violation of applicable Federal health insurance requirements (including failure to produce requested information).

(x) Such other information as the Trust may determine to be necessary to verify compliance with the requirements of this Act.

(B) REQUIRED DISCLOSURE.—The Secretary of Health and Human Services shall provide the Trust with all consumer claims data or information that has been provided to the Secretary by any health insurance plan that is offered through the National Health Insurance Exchange.

(C) PERIOD FOR PROVIDING INFORMATION.—Information to be provided to the Trust under this paragraph shall be provided by the Secretary within 30 days of the date of receipt of the request for such information, or within such extended period as the Secretary and the Trust mutually deem appropriate.

(5) NON-DISCLOSURE OF HEALTH INSURANCE DATA.—The Trust shall prevent disclosure of any data or information provided under this paragraph that the Trust determines is proprietary or qualifies as a trade secret subject to withholding from public dissemination. Any data or information provided under this paragraph shall not be subject to disclosure under section 552 of title 5, United States Code (commonly referred to as the Freedom of Information Act).

SEC. 7. DEFINITION OF NATIONAL HEALTH INSURANCE EXCHANGE.

In this Act, the term ''National Health Insurance Exchange'' means a mechanism established or recognized under Federal law for coordinating the offering of health insurance coverage to individuals in the United States through the establishment of standards for benefits, cost-sharing, and premiums for such health insurance coverage.

By Mr. CORKER (for himself, Mr. WARNER, and Mr. BENNETT):

S. 1280. A bill to authorize the Secretary of the Treasury to delegate management authority over troubled assets purchased under the Troubled Asset Relief Program, to require the establishment of a trust to manage assets of certain designated TARP recipients, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

Mr. CORKER. Mr. President, I rise to speak, briefly, about a bill Senator WARNER from Virginia and I are introducing today. The title of the bill is the TARP Recipient Ownership Trust Act of 2009.

This bill intends to deal with the issue that our government finds itself in a position of large ownership in companies—something I think none of us ever imagined would be the case some time ago.

This piece of legislation only deals with TARP recipients. But what it does is solve the unease in the problem that many of us have in the Senate and in the Congress with the fact that we have such large government ownerships in companies.

What this bill would do would be to set up a trust for all TARP company ownership to be put in when stakes are larger than 20 percent of the company. What it would do is give the administration the ability to appoint three trustees to have a fiduciary obligation to the taxpayers of this country. It would be my hope that these trustees would be people such as Warren Buffett or Jack Welch or people similar to them, whom we—all of us in our country—respect and consider to certainly be knowledgeable market participants.

These trustees will be paid no money. They would do this as a duty to our country. While their objective would be to look at these companies with a fiduciary responsibility to the taxpayers, they also would be given the direction to unload these ownerships by December 24, 2011. I think this would go a long way toward giving all of us more comfort that there was not a political agenda with any of these companies, that these companies were being dealt with in a way that is fair and appropriate to the taxpayers. I think this is something that, while it is not perfect, would do what is necessary to make us all feel a lot more comfortable about where we are.

No. 1, we would have three neutral, well-respected businesspeople looking after our taxpayers' interests. Hopefully, that would shield as much as possible any kind of political involvement in those companies. Secondly, obviously, they would be given the directive to unload this ownership by December 24, 2011, as I have mentioned. They can come back at that time. If they feel, for some reason, this is not in the taxpayers' interest, they can come back to us at that time and seek additional time, should they think it is in our interest as taxpayers to extend that period of time.

This is a bipartisan piece of legislation. This is not done with any kind of ax to grind. This legislation is being offered, truly, just to solve this rub we all find ourselves in, that the American citizens find themselves in, where we have large ownership stakes.

Specifically, today, because of the ownership stakes that exist, the three companies that would be affected would be AIG, Citigroup, and, of course, the automobile company, General Motors. There could be additional companies that, through conversions to common equity, might be affected by this.

I think this is a very commonsense piece of legislation that I hope will have broad bipartisan support.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 1280

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''TARP Recipient Ownership Trust Act of 2009''.

SEC. 2. AUTHORITY OF THE SECRETARY OF THE TREASURY TO DELEGATE TARP ASSET MANAGEMENT.

Section 106(b) of the Emergency Economic Stabilization Act of 2008 (12 U.S.C. 5216(b)) is amended by inserting before the period at the end the following: '', and the Secretary may delegate such management authority to a private entity, as the Secretary determines appropriate, with respect to any entity assisted under this Act''.

SEC. 3. CREATION OF MANAGEMENT AUTHORITY FOR DESIGNATED TARP RECIPIENTS.

(a) FEDERAL ASSISTANCE LIMITED.—Notwithstanding any provision of the Emergency Economic Stabilization Act of 2008, or any other provision of law, no funds may be expended under the Troubled Asset Relief Program, or any other provision of that Act, on or after the date of enactment of this Act, until the Secretary of the Treasury transfers all voting, nonvoting, and common equity in any designated TARP recipient to a limited liability company established by the Secretary for such purpose, to be held and managed in trust on behalf of the United States taxpayers.

(b) APPOINTMENT OF TRUSTEES.—

(1) IN GENERAL.—The President shall appoint 3 independent trustees to manage the equity held in the trust, separate and apart from the United States Government.

(2) CRITERIA.—Trustees appointed under this subsection—

(A) may not be elected or appointed Government officials;

(B) shall serve at the pleasure of the President, and may be removed for just cause in violation of their fiduciary responsibilities only; and

(C) shall serve without compensation for their services under this section.

(c) DUTIES OF TRUST.—Pursuant to protecting the interests and investment of the United States taxpayer, the trust established under this section shall, with the purpose of maximizing the profitability of the designated TARP recipient—

(1) exercise the voting rights of the shares of the taxpayer on all core governance issues;

(2) select the representation on the boards of directors of any designated TARP recipient; and

(3) have a fiduciary duty to the American taxpayer for the maximization of the return on the investment of the taxpayer made under the Emergency Economic Stabilization Act of 2008, in the same manner and to the same extent that any director of an issuer of securities has with respect to its

shareholders under the securities laws and all applications of State law.

(d) LIQUIDATION.—The trustees shall liquidate the trust established under this section, including the assets held by such trust, not later than December 24, 2011, unless the trustees submit a report to Congress that liquidation would not maximize the profitability of the company and the return on investment to the taxpayer.

SEC. 4. DEFINITIONS.

As used in this Act—

(1) the term ''designated TARP recipient'' means any entity that has received, or will receive, financial assistance under the Troubled Asset Relief Program or any other provision of the Emergency Economic Stabilization Act of 2008 (Public Law 110-343), such that the Federal Government holds or controls, or will hold or control at a future date, not less than a 20 percent ownership stake in the company as a result of such assistance;

(2) the term ''Secretary'' means the Secretary of the Treasury or the designee of the Secretary; and

(3) the terms ''director'', ''issuer'', ''securities'', and ''securities laws'' have the same meanings as in section 3 of the Securities Exchange Act of 1934 (15 U.S.C. 78c).

By Mr. BROWNBACK (for himself, Mr. ALEXANDER, Mr. CHAMBLISS, Mr. COBURN, Mr. CORKER, Mr. CORNYN, Mr. CRAPO, Mr. ENSIGN, Mr. ENZI, Mr. GRAHAM, Mrs. HUTCHISON, Mr. INHOFE, Mr. ISAKSON, Mr. JOHANNS, Mr. KYL, Mr. MARTINEZ, Mr. MCCAIN, Mr. RISCH, Mr. THUNE, Mr. VITTER, and Mr. VOINOVICH):

S. 1282. A bill to establish a Commission on Congressional Budgetary Accountability and Review of Federal Agencies; to the Committee on Homeland Security and Governmental Affairs.

Mr. BROWNBACK. Mr. President, I want to follow up on what my colleague from North Dakota said regarding the financial regulatory issue. This is a huge problem.

In my office, I have a debt clock running. I put it there purposely so people can see what it is, and it is running at $11.5 trillion. At this point in time, it has a dizzying amount of numbers that are running on it. Usually my constituents come in and say: Good, I wanted to get out of the waiting room. That clock is driving me crazy, the numbers are going so fast. It is so huge, the numbers and the rate we are going.

What troubles me as well, as a member of the baby boomer generation, is that I look at this and I feel as though we are following on the heels of the ''greatest generation''—the World War II generation, with all the sacrifices and the things they did to make this country what it is. My predecessor in the seat I am in, Bob Dole, I think epitomizes the ''greatest generation''—the World War II generation—that sacrificed so much so the rest of us could live and do so well, and I am deeply appreciative of that. But I look at my generation, sometimes called the ''me generation.'' I don't know that that is particularly an applauding sort of title, saying it is more focused that way, but I think we need to, ourselves, step up a lot more for the country, for the people in this Nation, and deal with the problems we have.

One of the biggest ones, as far as the legacy we leave, is the mortgage that is growing on this country, this $11.5 trillion I started off talking about. When I first started in Congress in 1994, it was roughly 50 percent mandatory spending and 50 percent discretionary spending. This year, we are looking at 70 percent mandatory spending—between 60 and 70 percent mandatory spending, depending on what ends up in the final package—and 30 to 40 percent discretionary spending. And of that discretionary, half of that is military. So we have this huge growth in entitlement programs and spending programs that are on autopilot and that are setting that clock to going faster and faster, at $11.5 trillion and up.

We are looking at a $1.8 trillion deficit this year alone. This is unsustainable and it is irresponsible. And it is irresponsible of the baby boomer generation, which has inherited and been given so much, not to step up and to start to deal with this. I feel very strongly about this, that it is something we need to start dealing with as a generation. I am not talking about from a party perspective, or even from a legislative perspective, but I am talking about it from a generational perspective. This is the sort of thing we need to start dealing with for our children's future and our grandchildren's future, so that when future generations come up and they look back and see the ''greatest generation'' of World War II, they don't then look at the baby boomer generation and say: Well, that is the generation that used a lot of it up. Rather, they say: No, that was the generation that used a lot, but then got it together and started to address the problems of fiscal irresponsibility—the fiscal irresponsibility that is taking place in this country and in this government today.

We have program spending that is out of control. Everybody is against waste, fraud, and abuse, but I have not found that line in the budget yet which allows us to X it out. What I am talking about here—and I will introduce at the end of my speech—is a bill that actually does start to get at that, and it does it via a mechanism that is a proven mechanism we have used before in this body which actually reduced government spending. It is called the Commission on Accountability and Review of Federal Agencies, CARFA. We have 20 original cosponsors, and it is a very simple concept that we have used before.

It is based on the BRAC Commission—the Base Realignment and Closure Commission—only it applies to the rest of government, not just military bases. You create a commission, and the commission says 300 bases should be closed. They send that to the administration to check off on that, and then it sends it to the Congress, requiring an up-or-down vote within a limited timeframe, no amendments and a set amount of time to debate. Yes or no, deal or no deal: Are we going to keep the bases or close the bases, which way is it?

That is the only mechanism I have ever seen us come up with in this body to actually cut Federal spending and to do the things we talk about all the time but in the trading nature of the legislative body never gets done. This one has actually done it, the BRAC Commission, on military bases, which is a substantial but certainly not all of our budget. So I am saying, let's take that mechanism and apply it to the rest of the budget, mandatory and discretionary spending, both pockets of this.

I am fully open to suggestions and ideas for amendment on this bill, but I would break the Federal Government into four different categories, to where every fourth year there is a CARFA commission which reviews one-fourth of the budget, and then that recommendation is sent to the Congress to either eliminate these pieces or to keep them.

I have a scorecard up here. It turns out that the OMB does a regular scoring of the effectiveness of Federal Government programs and then they assign a percentage out of 100 to each. I put the grade equivalent on it, and you can see the programs that were reviewed here: State Department has the highest score that I have up here, of C+ for effectiveness, at which the OMB scored it. The Education Department—and I don't know what that says here—has scored below 50 percent and gets an F—the Education Department—on its scorecard. You can look through and these are the programs that are reviewed: 51 for the State Department; 93 for the Education Department.

So I am saying you would have this CARFA commission go through to do a similar type of review for effectiveness. Those programs that would fail would be put in an overall bill which would say: Okay, Congress, keep this entire package or eliminate this entire package.

If you eliminate them, the same year you can come back and reauthorize that bill and reappropriate the program if you believe it is effective. But this gives you an automatic culling process. It is a culling process that takes place on programs that have been put in the budget year after year and have somehow been sustained or have gotten supporters around them. Most programs have a number of different supporters around them, so they keep going on and on. Even though they are not particularly effective, the supporters like them, so they keep getting in the budget, even when we do an objective review of them and find out these are failed programs by our own standards.

This is something we need to do. It is something I would hope that the baby boomer generation could stand up and

start to say it is time for us to take fiscal responsibility for the situation that is being created and that is unsustainable in this country. We are already starting to see interest rates move up. That is likely to continue. We are seeing people beside themselves when looking at the level of Federal spending, and the waste in it, and saying: What is going on? Can't you guys get ahold of it?

Here is a way to actually get ahold of it and deal with it and be able to say to generations in future years that, yes, we stood up and took ownership and we dealt with the problem.

There was an article in the Wall Street Journal a week ago where a gentleman was saying that the unfunded obligations of the Federal Government today—these are things such as the entitlement programs, whether it is Medicare, Social Security, veterans' benefits, and pension guarantees that we have—are getting close to $100 trillion. Those are unfunded obligations existing on the part of the Federal Government today. That number seems high to me, but I know if you look at Medicare and a couple of other ones, we are looking at nearly $60 trillion in that category. To give some perspective, the total economy is $14 trillion, or thereabouts.

This is irresponsible to the highest degree, and it is irresponsible to future generations, and it is time to put a mechanism in place for us to deal with it. I urge my colleagues to join us in cosponsoring this bill. I am submitting it now to the desk, with 20 cosponsors. This is an idea whose time has come.

By Ms. SNOWE (for herself and Mrs. BOXER):

S. 1284. A bill to require the implementation of certain recommendations of the National Transportation Safety Board, to require the establishment of national standards with respect to flight requirements for pilots, to require the development of fatigue management plans, and for other purposes; to the Committee on Commerce, Science, and Transportation.

Ms. SNOWE. Mr. President, I rise today to join with my colleague, Senator BOXER, to introduce the One Level of Safety Act. We have all become familiar with the events surrounding the terrible tragedy near Buffalo, New York—an accident that the National Transportation Safety Board categorized as the worst such incident since late 2001—that cost fifty lives, and shattered countless others. In the wake of the crash of Flight 3407, we have identified failures on a multiplicity of levels. For an agency that has consistently cited its commitment to ''one level of safety'' for all carriers as far back as 1995, this accident showcases that when it comes to regional carriers, the Federal Aviation Administration has done a poor job of enforcing that philosophy.

During its preliminary investigation of Flight 3407, the National Transportation Safety Board pointed out a number of issues specific to this accident that could be directly attributable to fatigue, with many pilots traveling all night over great distances just to reach their base of operations. For example, almost a quarter of Colgan Air pilots who operate out of Newark, New Jersey travel over one thousand miles simply to reach their designated duty station. At the same time, as we've witnessed with a number of regional carriers, pilots are often paid meager salaries—the first officer in Flight 3407 made barely twenty thousand dollars annually.

With such low pay, it is difficult for these pilots to provide for themselves and their families, much less afford a restful place to spend an evening; at a hotel, or an apartment in close proximity to their base of operations—as a result, they doze in airport lounges—technically against most airline regulations—and subsequently are getting into the cockpit fatigued, with insufficient rest and, potentially, reduced situational awareness. With little oversight concerning the amount of rest these pilots receive, we face the terrible potential for another incident in the near future.

I was greatly encouraged by the efforts that the new Federal Aviation Administrator Babbitt undertook on Monday; his announcement to initiate rulemakings on fatigue management, the relationship between major and regional carriers, and training discrepancies, were all positive, proactive steps to help remedy a situation that for too long has gone ignored, and I commend his willingness to take the reins so early in his tenure. Unfortunately, as a recent series of hearings at the Senate Commerce Committee has shown us, rulemakings are typically long, drawn-out processes that in some cases are never completed. Simply put, this is insufficient.

In fact, a National Transportation Safety Board recommendation concerning pilot fatigue—clearly an underlying cause of the Flight 3407 crash—has been outstanding for nearly 2 decades! This recommendation was no small suggestion; it has been on the NTSB's highest profile publication, their Most Wanted List, for nineteen years! Given that four of the last six fatal accidents involving commercial carriers included fatigue as a contributing cause, I am stunned that this issue has not been addressed. But only one effort to tackle this issue has been made in the past 2 decades, and after encountering some resistance, that proposed rulemaking was shelved in 1995, and no second attempt was forthcoming. So, while the Federal Aviation Administration's comments yesterday were laudable, there are no guarantees when it comes to rulemakings. I believe it is incumbent on Congress to act and act now.

That is why Senator BOXER and I joined together to develop legislation that we believe will close many of the loopholes that jeopardize safety, those same loopholes spotlighted by the findings of the National Transportation Safety Board, the Department of Transportation Inspector General's office, and the victims' families of Flight 3407. Requiring the Federal Aviation Administration to complete a number of long-overdue rulemakings on issues as wide-ranging as fatigue management, minimum training standards for all carriers, and remedial training for deficient pilots is the first step. Ensuring the Federal Aviation Administration will perform adequate, unannounced inspections to guarantee these new rules are enforced, and requiring more rigorous inspections of flight schools like the Gulfstream Academy—whose parent company was recently assessed a civil penalty of $1.3 million for safety violations, and where many regional pilots receive their training—will go a long way towards closing the loopholes that still exist in our aviation safety network. In my view, these are all positive steps that will prevent another incident like the crash of Flight 3407.

Before I close, I would like to say a word to the families of the crash victims. I deeply empathize with your loss, and in large part, your efforts have been essential in the drafting of this legislation. Thank you for all your perseverance and invaluable contributions during what I know must be difficult times for all of you.

Mrs. BOXER. Mr. President, like many of my colleagues, I was shocked and saddened by the commuter plane crash last February outside of Buffalo, NY. Sadly, Clay Yarber, a resident of Riverside, CA, was one of the 50 victims of this tragic crash.

I would like to offer my deepest condolences to the family and friends of Mr. Yarber and to all of the families dealing with such horrific loss.

The crash of Continental flight 3407 has had a significant impact on how Americans across the country view air travel and has raised serious questions about the safety and oversight of our Nation's aviation system.

Initial hearings held this past May by the National Transportation Safety Board, NTSB, brought to light many unsettling revelations about pilot training, hours of experience, fatigue, and the FAA's oversight role of regional airlines.

I was greatly disturbed by what appeared to be a lack of proper training for the pilots on how to recover from a stall, how to proceed in icing conditions, and reports of the crew commuting cross country without proper rest prior to the flight.

Although regional airlines account for one-half of all of the scheduled flights in the U.S., five of the last seven fatal commercial plane crashes involved these airlines.

As more Americans rely on commuter airlines for air service, the FAA must take aggressive action to ensure that there is no difference in the level of safety provided by these air carriers.

The National Transportation Safety Board, NTSB, hearings also made clear that the FAA must be more proactive when it comes to safety. We must not wait until the next disaster to make long overdue changes in safety regulation at the FAA.

It is unacceptable that the NTSB recommendations designed to address some of the most serious aviation safety deficiencies continue to go unaddressed by the FAA today.

Last May, I joined Senator SNOWE in sending a letter to the Department of Transportation urging the agency to take immediate action to address NTSB recommendations that languished on its Most Wanted list for years and other pressing safety concerns.

In some instances, recommendations such as those meant to address pilot fatigue, have been on the NTSB Most Wanted list since its inception 19 years ago. We must take immediate action to ensure that no other family must endure a similar tragedy because of unmet safety recommendations and a lack of agency oversight.

I was encouraged by recent announcements from the FAA about the agency's initiative to revise work hour rules to address pilot fatigue and to conduct emergency inspections at pilot training facilities. I believe this is a step in the right direction, but we must do more.

That is why I am proud to join Senator SNOWE in introducing the Ensuring One Level of Aviation Safety Act of 2009, to address some of the more egregious aviation safety deficiencies. Our bill requires the FAA to implement unfulfilled NTSB recommendations and to do more oversight of regional airlines and pilot training academies. The bill also requires the FAA to update minimum training standards and hours of experience requirements for pilots.

Finally, this legislation mandates continuing education training for pilots, requires the development of airline fatigue management plans, and allows carriers immediate access to pilot performance records.

I look forward to working with my colleagues and the FAA to implement this legislation and to take additional steps to ensure that there truly is no difference in safety between major carriers and regional airlines.

We cannot wait for the next airline tragedy to take action. The flying public must be assured that the FAA and the airlines are doing their part to make safety the No. 1 priority.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 187—CONDEMNING THE USE OF VIOLENCE AGAINST PROVIDERS OF HEALTH CARE SERVICES TO WOMEN

Mrs. SHAHEEN (for herself, Ms. KLOBUCHAR, Mrs. BOXER, Mrs. MURRAY, Mr. DURBIN, Mr. DODD, Mr. SCHUMER, Mr. LAUTENBERG, Ms. MIKULSKI, Ms. LANDRIEU, Mrs. GILLIBRAND, Mr. HARKIN, Mr. CARPER, Mr. SANDERS, Mr. KAUFMAN, Mr. WYDEN, Mr. KERRY, Mr. LIEBERMAN, Mr. UDALL of New Mexico, Mr. LEVIN, Mr. BROWN, Mr. WHITEHOUSE, Mr. BURRIS, Mr. UDALL of Colorado, Ms. STABENOW, Mr. BAUCUS, Ms. CANTWELL, Mr. BINGAMAN, Mr. INOUYE, Mr. CARDIN, Mr. SPECTER, Mr. JOHNSON, Mr. FEINGOLD, Mr. LEAHY, Mr. TESTER, Ms. SNOWE, Mr. BEGICH, Mr. AKAKA, Mr. BENNET, Mrs. FEINSTEIN, Mr. WARNER, Mrs. MCCASKILL, Mr. REED, Mr. KENNEDY, Mr. MERKLEY, and Mrs. LINCOLN) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 187

Whereas Dr. George Tiller of Wichita, Kansas, was shot to death while attending church on Sunday, May 31, 2009;

Whereas there is a history of violence against providers of reproductive health care, as health care employees have suffered threats, hostility, and attacks in order to provide crucial services to patients;

Whereas the threat or use of force or physical obstruction has been used to injure, intimidate, or interfere with individuals seeking to obtain or provide health care services; and

Whereas acts of violence are never an acceptable means of expression and shall always be condemned: Now, therefore, be it

Resolved, That the Senate—

(1) expresses great sympathy for the family, friends, and patients of Dr. George Tiller;

(2) recognizes that acts of violence should never be used to prevent women from receiving reproductive health care; and

(3) condemns the use of violence as a means of resolving differences of opinion.

SENATE RESOLUTION 188—CONGRATULATING THE LOS ANGELES LAKERS FOR WINNING THE 2009 NATIONAL BASKETBALL CHAMPIONSHIP

Mrs. BOXER (for herself and Mrs. FEINSTEIN) submitted the following resolution; which was considered and agreed to:

S. RES. 188

Whereas, on June 14, 2009, the Los Angeles Lakers defeated the Orlando Magic in game 5 of the 2009 National Basketball Association Championship Finals;

Whereas that triumph marks the 15th National Basketball Association Championship for the Lakers franchise and 10th for the Los Angeles Lakers;

Whereas that triumph also marks the fourth National Basketball Association Championship victory for the Los Angeles Lakers since 1999, earning the Los Angeles Lakers more championship victories in this decade than any other team in the league;

Whereas Los Angeles Lakers head coach Phil Jackson, who throughout his career has epitomized discipline, teaching, and excellence, has won 10 National Basketball Association Championships as a head coach, the most championships for a head coach in National Basketball Association history, surpassing the number won by the legendary Arnold ''Red'' Auerbach;

Whereas the 2009 National Basketball Association Championship marks the ninth championship for Los Angeles Lakers owner Gerald Hatten Buss;

Whereas general manager Mitch Kupchak has built a basketball team that possesses a great balance among all-stars, veterans, and young players;

Whereas the Los Angeles Lakers won 65 games in the 2009 regular season and defeated the Utah Jazz, the Houston Rockets, the Denver Nuggets, and the Orlando Magic in the 2009 National Basketball Association playoffs; and

Whereas each player for the Los Angeles Lakers, including Trevor Ariza, Shannon Brown, Kobe Bryant, Andrew Bynum, Jordan Farmar, Derek Fisher, Pau Gasol, Didier Ilunga-Mbenga, Adam Morrison, Lamar Odom, Josh Powell, Sasha Vujacic, Luke Walton, and Sue Yue, contributed to what was truly a team effort during the regular season and the playoffs to bring the 2009 National Basketball Association Championship to the city of Los Angeles: Now, therefore, be it

Resolved, That the Senate—

(1) congratulates the Los Angeles Lakers for winning the 2009 National Basketball Association Championship;

(2) recognizes the achievements of the players, coaches, and staff whose hard work and dedication made winning the championship possible; and

(3) directs the Secretary of the Senate to transmit a copy of this resolution to—

(A) the 2009 Los Angeles Lakers team and their head coach Phil Jackson;

(B) the Los Angeles Lakers owner Gerald Hatten Buss; and

(C) the Los Angeles Lakers general manager Mitch Kupchack.

AMENDMENTS SUBMITTED AND PROPOSED

SA 1321. Mr. GRAHAM submitted an amendment intended to be proposed by him to the bill S. 1023, to establish a non-profit corporation to communicate United States entry policies and otherwise promote leisure, business, and scholarly travel to the United States; which was ordered to lie on the table.

SA 1322. Mr. INHOFE (for himself and Mr. COBURN) submitted an amendment intended to be proposed by him to the bill S. 1023, supra; which was ordered to lie on the table.

SA 1323. Mr. LIEBERMAN submitted an amendment intended to be proposed by him to the bill S. 1023, supra; which was ordered to lie on the table.

SA 1324. Mr. FEINGOLD submitted an amendment intended to be proposed by him to the bill S. 1023, supra; which was ordered to lie on the table.

SA 1325. Mr. BROWNBACK (for himself, Mr. KYL, Mr. CRAPO, Mr. ROBERTS, Mr. RISCH, Mr. COBURN, Mr. CORNYN, Mr. BOND, Mr. INHOFE, Mr. DEMINT, Mr. BUNNING, Mr. BENNETT, Mr. CHAMBLISS, and Mr. JOHANNS) submitted an amendment intended to be proposed by him to the bill S. 1023, supra; which was ordered to lie on the table.

SA 1326. Mrs. FEINSTEIN (for herself and Mr. LIEBERMAN) submitted an amendment intended to be proposed by her to the bill S. 1023, supra; which was ordered to lie on the table.

SA 1327. Mr. REID (for Mr. KENNEDY (for himself and Mr. KERRY)) submitted an amendment intended to be proposed by Mr. REID to the bill S. 1023, supra; which was ordered to lie on the table.

SA 1328. Mr. COBURN submitted an amendment intended to be proposed by him to the bill S. 1023, supra; which was ordered to lie on the table.

SA 1329. Mr. CORKER (for himself and Mr. WARNER) submitted an amendment intended to be proposed by him to the bill S. 1023, supra; which was ordered to lie on the table.